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ABSTRACT

These guidelines on the uses of individualized and fixed curriculum approaches to instruction were developed for persons responsible for conducting professional continuing education programs in mental health. Following a brief introduction and definitions of terms, major content is presented in three sections covering the following areas: the unique needs for continuing education in mental health, the characteristics of the fixed curriculum and individualized approach to instruction and criteria for using each of these approaches, and practical considerations and recommendations for fixed curriculum and individualized learning approaches, including assessing needs for the program, setting program objectives, gaining sanctions, funding and costing, promotion, instruction, faculty, evaluation, and credentialing. Finally, a summary concludes these guidelines. (EM)

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SELECTING APPROPRIATE INSTRUCTIONAL APPROACHES

CONTINUING EDUCATION IN MENTAL HEALTH

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FOREWORD

In late 1975 the Mental Health Program of the Southern Regional Education Board received a grant (No. 1-T15-MH14098) from the Continuing Education Branch of the National Institute of Mental Health to strengthen continuing education for mental health throughout the 14 states of the South. The project conducted a survey of continuing education activities then underway in the professional schools, professional societies and mental health agencies (both state and community) of the South to learn more of the needs and problems which are being encountered. Responses brought out that there were several areas of general concern: funding; needs assessment; evaluation; gaining sanction for continuing education; credentialing; greater clarification of continuing education responsibilities between the professional schools, the professional societies and mental health agencies; continuing education for paraprofessionals; and continuing education for community caregivers.

A major strategy of the project has been to appoint task forces of small groups of knowledgeable persons to explore some of these issues in detail and to prepare guideline publications which might be of use to persons presently responsible for conducting continuing education programs in mental health or for those persons who might be coming into positions where they will be developing programs in the future.

We are grateful to the members of the task force who helped to develop these guidelines in the uses of individualized and fixed curriculum approaches to continuing education in mental health and to the National Institute of Mental Health for support of this entire project.

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SELECTING APPROPRIATE INSTRUCTIONAL APPROACHES
TO
CONTINUING EDUCATION IN MENTAL HEALTH

TABLE OF CONTENTS

Introduction 1

Definitions. 5

Unique Needs For Continuing Education in
Mental Health. 11

Characteristics of Fixed Curricula and
Individualized Learning Approaches 15

Practical Considerations and Recommendations 23

Summary. 41

Task Force Members 45

INTRODUCTION

Until recently there has been little systematic attention to continuing education in mental health. The field has traditionally been led by a handful of major professions (psychiatry, psychology, social work and nursing), each of which trained and certified individuals with no concern for future change or development. However, the past ten years have seen great changes in the technology and concepts of mental health. There are now new treatment methodologies (e.g., new psychotropic medications, behavior therapy, reality therapy), new modes of service delivery (e.g., consultation, education, community planning), and new administrative forms (e.g., community mental health centers, alcohol and drug abuse programs, social rehabilitation programs and hot lines). It has become necessary to establish a range of continuing education programs to help staff persons at all levels to keep up-to-date with the new technologies and to help them function effectively in the delivery programs and agencies.

There have been sporadic continuing education programs carried out by various parts of the mental health manpower system over the past fifty years. Most prominent of these efforts were the scientific programs and journals of the professional societies. These were conceptualized more as scientific sessions concerned with new scientific and clinical discoveries than as continuing education programs concerned with helping practitioners solve their practice problems, but they were the best that was available. There were also periodic lecture series conducted by professional schools for practicing professionals, but they were rare. None of

these programs paid much attention to educational issues, and none was accredited or awarded certificates of credits.

Today the situation is much more complicated. In response to changes in the mental health delivery system and the pressures from third party payers and government for quality assurance, a bewildering array of continuing education programs in mental health has developed. Some are sponsored by professional societies, some by professional schools, some by operating agencies and some by profit making groups or voluntary associations. Some are long-term, others are short-term. Some are accredited and award certificates, while others do not. Some remain focused on scientific lectures which are conducted exclusively for members of a single profession. Others use experiential learning techniques and are more directed to improving the delivery programs for multidisciplinary programs. With all of this activity there has been little attention to the means of coordinating and relating all of this continuing education to the broad field of mental health -- a delivery system made up of many professions, agencies and caregivers using a wide range of technologies and delivery forms.

In the field of adult and continuing education there are two distinctive approaches to planning and conducting continuing education. One of these is the traditional educational approach of having a <u>fixed curriculum</u> in which the goals and objectives, content and learning experiences are set forth in relatively standard packages which are applied to all enrolled learners. The other approach is a more <u>individualized curriculum</u> in which the goals and objectives are set forth in rather specific terms, but the learning experiences and time frames are varied according to the needs of the individual learners. Each approach has its proponents. Actually both have their place in continuing education in mental

health. However, there are few guidelines for the educational planner to use in deciding which approach is more appropriate for which situation. There are times when the two approaches overlap and blend. The purpose of this publication is to explore some of the indications and limitations of each of these approaches for continuing education in mental health.

DEFINITIONS

For purposes of this report it is desirable to agree upon the definition of certain terms so that we can "box the compass" for further discussions. Among key terms are:

> Continuing Education -- any systematic learning experiences needed to improve, modify or update one's knowledge, skills or values in areas of professional or occupational practice.

This definition differs from those used in other publications. Some definitions include the notion of any kind of life-long learning in the concept of continuing education (i.e., learning to play golf, to appreciate art or to raise orchids). The definition for purposes of this publication, is limited to professional or occupational practice.

Other authors would limit the definition to formally accredited programs, or even to programs sponsored by colleges or universities. The definition used here is not so restrictive, but also includes programs sponsored by operating agencies, professional societies or private and voluntary associations. This definition also includes regular reading programs and programmed instruction materials, but not casual readings or attendance at professional society business meetings. The learning experience does not need to be accredited or systematically evaluated to meet this definition, although it is desirable that any continuing education program be assessed.

Mental Health -- the field of knowledge and applied techniques which is concerned with mental and emotional health and illness of the population and the social systems which help those who function poorly to enhance their psycho-social functioning.

This includes all of the areas of mental illness, mental retardation, emotional disturbance, alcohol and drug abuse, as well as prevention of these conditions and promotion of the mental health of the population at large. It is not restricted to what mental health agencies and their staffs do, but extends to any activities of other community agents or agencies which affect the mental health of the people. It encompasses at least three major areas of competence:

Clinical knowledge and skills about the causes and diagnoses of various emotional or mental disabilities and the skills to intervene on behalf of individuals or small groups.

This is the area of professional competence that is traditionally offered in pre-professional training and in continuing education. It is a basic and essential aspect of mental health practice, but it is often not sufficient to provide for the efficient delivery of mental health services.

Knowledge and skills for the delivery of mental health services to clients and communities.

These service delivery skills go beyond the basic clinical skills of diagnosis and treatment and include such competencies as prevention, mental health education, consultation, and rehabilitation. They also include such concepts as the use of teams, community process skills, assuring patient compliance and maintaining support systems for clients who have been released from acute treatment but still require extensive assistance in order to function in the community.

Knowledge and skills for administration of programs, funds, and personnel to deliver mental health services.

Most mental health professionals (and even paraprofessionals) soon find themselves involved in administrative or supervisory responsibilities for units of programs or for entire programs. Often these persons have administrative or supervisory responsibilities in addition to their clinical and service delivery

duties. Very few pre-professional training programs prepare their graduates for any kind of administrative skills. This area is left either to continuing education or to the "school of hard knocks."

The four major component actors in the mental health continuing education system are: a) the professional schools, b) the professional societies, c) the operating mental health agencies, and d) private and voluntary groups. They are all relative newcomers to the field of continuing education -- a field which itself is new and not yet well conceptualized.

Academia -- the formally structured educational system.

This includes all components in public and private colleges and universities, community colleges, and technical centers, as well as governing bodies, such as boards of higher education. The professional schools of the major mental health professions are usually located in universities or colleges.

Professions -- organizations of professional, technical or occupational groups focused on the improvement of their members individually and collectively.

Often the professions are strongly oriented to political advocacy and protection of their prerogatives, but they are also oriented to the betterment of their members through scientific programs, journals, training endeavors and certification and licensure activities. This definition includes paraprofessional organizations and affiliated organizations, such as the American Public Welfare Association, the American Public Health Association, or the American Association on Mental Deficiency.

Agencies -- formally structured organizations which deliver mental health services.

The usual provider agencies of mental health services are state mental health agencies, community mental health centers, mental hospitals, schools for the retarded, alcohol and drug programs, children's programs and counseling centers. In addition to these, Health Systems Agencies, Professional Standards Review Organizations, and mental health associations might be considered to be agencies. The term includes public, private and voluntary organizations, which are concerned about the ability of their staffs to carry out the clinical, programmatic and administrative functions for which they are responsible.

> The Private and Voluntary Sector -- those individuals, companies and proprietary groups which provide continuing education on a profit-making or cost basis.

This refers to firms and private consultants which sponsor workshops, media functions, programmed instruction and training conferences. It includes private consultants, pharmaceutical corporations, profit oriented institutes, proprietary educational organizations and associations, such as the American Management Association, which have other purposes but which also sponsor continuing education programs on a cost or profit-making basis.

The private and voluntary sectors are not a part of the official system, but they have come into being to meet current demands. It is important that their role be more sharply defined and recognized by persons in the official system.

> Competency -- the ability to perform a specified skill, task, activity or function at a defined level of adequacy.

This definition stresses the notion of performance which requires knowledge, combined with some action. The action requires skills and probably a value base (especially in human service work) in order to translate the knowledge into appropriate performance.

In this document the word competency may apply to elements of clinical practice, service delivery or program administration. For these competencies the learner must have the requisite knowledge, theory, principles and concepts, but he has not demonstrated competence until he has performed tasks or functions based on that knowledge.

Curriculum -- a particular course of study.

This definition frequently, but not necessarily, implies a fixed schedule of didactic exercises directed to a specific set of objectives. In the traditional sense a curriculum is heavily oriented to a pattern of academic facts, theories, principles and concepts which all students are expected to master on a test. At the extreme this is represented by the college curriculum which obligates each student to take certain required courses and distributional requirements even though he may already have competence in some of those subjects.

A broader concept of curriculum includes the whole body of learning experiences offered to the student. These include social learning and value clarification related to performance as well as the knowledge and skill components.

UNIQUE NEEDS FOR CONTINUING EDUCATION IN MENTAL HEALTH

Many of the traditional concepts of education grew from the need to have students master specific skills which were felt to be needed by everyone and which required relatively standard performance by all students. This was true of reading, writing and arithmetic in the elementary schools. It is often typical of adult basic education in which the goal is the teaching of basic literacy or retraining in specific motor skills for new jobs.

However, as one moves to continuing education for the professions, the situation becomes more complex. The knowledge base and the skill base become more complicated. There are many combinations of ways in which the professional worker may satisfactorily solve problems. There is often no single right or wrong way, but rather there are methods which work well for certain practitioners and not so well for others, or to quote an expression often used by surgeons, "There are certain procedures that work well in my hands."

In the field of mental health this individualization becomes even more significant because mental health work depends so much on the practitioner's use of his or her own personality and style to accomplish the therapeutic results. To be sure, there is a knowledge base and a skill base, but these are applied through individual practitioners. The knowledge and skills are passed through the lens of such individual's personality and value system. It is inappropriate to teach just one <u>right</u> way; rather, what is the <u>best</u> way for each individual

practitioner to help his or her clients or to administer his or her program should be explored. Competence in mental health is such an individual matter that it is difficult to fit into the standard educational framework.

In addition, of course, each worker faces a different set of problems and needs in the patients he or she serves. Each patient presents a complex and unique set of problems, no two of which are likely to be the same. This is different from the situation which is likely to prevail in much of industry where each item manufactured or serviced is expected to fit a standard. In the human services the worker needs to learn what makes him better able to solve his client's problems, rather than to carry out certain preordained tasks. For those aspects of a worker's job which require a specific body of knowledge or specific skills, a certain level of structured training should be retained, but even this should be flexible enough to relate to the individual needs of both the worker and the clients.

The situation regarding continuing education in the field of mental health is further complicated by the fact that some of the major needs which must be addressed through continuing education are those of: a) the delivery of mental health services, and b) the administration of mental health programs. Both of these are derived from basic clinical knowledge and skills, but they involve creative ways of delivering that body of knowledge and skills -- not through direct patient services, but through consultation, education, teams of workers, and organized programs and agencies. Basic professional education provides a good basic education for direct patient care, but gives little attention to the complexities of the delivery system and the administration of that system.

These tasks remain for continuing education, but the knowledge base is far less certain, and their practice requires even greater subtleties of skills, values, and personal style than does basic patient care.

In all of continuing education for mental health the competencies are broader than in much of basic education. The practitioner's values, attitudes, personality and problem-solving behaviors are as important as the knowledge and skills to carry out specific tasks. The training then would seem to require a much more flexible and personalized approach then in many other parts of adult education.

With this background of the special needs and problems facing hhe field of continuing education for mental health the following material explores some of the issues regarding the uses of fixed curricula versus the uses of individualized educational approaches in the continuing education process.

CHARACTERISTICS OF FIXED CURRICULA AND INDIVIDUALIZED LEARNING APPROACHES

While there is no firm dichotomy between a fixed curricular approach to education and an individualized learning approach, there are characteristics of each to be considered in planning and conducting continuing education programs in mental health.

The classical fixed curriculum assumes that all learners are starting at the same level and that all learners must meet the specified objectives by the end of the instructional program. The instructor plans the instructional program and evaluation procedures so that they can be clearly announced in advance. There is less emphasis on individual need and more on course objectives which the class as a group is expected to meet. The instructional units are standardized, and the program is easy to describe for accreditation or administrative purposes.

The individualized learning approach may set similar overall objectives to those of the fixed curriculum approach, but it attempts to assess the needs and problems of each participant in reaching those objectives. It then evaluates each learner's existing level of competence and the reasons for the gaps so that an individualized training program can be planned which will help the learner achieve the objectives in the areas in which he is found to be deficient. Since it is often not clear at the start of a program just what each individual's needs and problems are, the instructor must remain flexible to change his lesson

plan to deal with newly emerging factors. Individuals are described as competent when they can meet the prevailing standard of performance for a particular activity or function regardless of the time frame or the instructional sequence required by the learner to accomplish that level of competence.

Both approaches require three basic steps:

Identifying the behaviors of an effective worker in a given setting;

Designing a program which produces these competencies;

Developing evaluation devices to ascertain whether the learner has attained the competencies.

The differences lie in the fact that the fixed curriculum approach is standardized for all learners whereas the individualized learning approach makes an additional assessment at the start to ascertain the degree to which each learner already posseses the competencies and the problems he may encounter in achieving the remainder. Instructional programs are then designed to meet those specific needs of each individual learner.

The following section identifies some of the characteristics and indications for the use of these approaches.

FIXED CURRICULUM APPROACH	INDIVIDUALIZED LEARNING APPROACH
Learning Objectives	
Appropriate for standardized knowledge or skills.	More useful when the objectives are not specific behaviors but reflect personal or organizational growth.
Appropriate for subject-centered objectives.	More useful for problem-centered objectives.
Appropriate for externally ordered objectives.	More appropriate for self-determined objectives.

FIXED CURRICULUM APPROACH	INDIVIDUALIZED LEARNING APPROACH
Assessment of Need	
Often decreed by management or faculty.	Often done by self assessment and learner preferences.
Often related to specific tasks or behaviors.	More often related to problems and modifications of problem behaviors rather than absolute behaviors.
Number of Learners	
Preferred for large groups.	Preferred for small numbers.
Appropriate for several repetitions of the same material.	Useful for programs which must be modified for each new group of learners.
Nature of Learners	
Useful when learners are at the same level of training and experience.	Useful when learners are at different levels of training and experience.
More appropriate when all learners are from the same discipline.	Preferable for learners from various disciplines.
More appropriate when learners have similar demographic characteristics (age, sex, race, marital status, etc.).	Preferable for learners with unlike demographic characteristics.
Learners are relatively passive.	Learners have active role.
Nature of the Problem to be Addressed	
Appropriate when the problem is a simple deficiency of knowledge or skill.	More suitable when the problem is a defect in complex problem solving behavior.
Appropriate when the problem requires standardized behaviors.	More suitable when the problem requires personalized or specialized tailored behaviors.

FIXED CURRICULUM APPROACH	INDIVIDUALIZED LEARNING APPROACH
Funding	
Easier to obtain since the approach is traditional and businesslike.	May be difficult to fund if flexible pattern seems too soft-headed.
Unit costs tend to be low and uniform.	Unit costs may be high.
More easily funded if the program is to be repeated several times.	Agency may prefer if released time is flexible for each learner-employee.
Credentialing	
Easy to accredit as it fits classical models.	Flexible program is more difficult to accredit -- especially when "hours" are important.
Appropriate when credentials are based on "hours."	Appropriate when credentials are based on demonstrated competence.
Instructors	
Tend to be more "teacher" oriented.	Tend to be more colleagual and consultative.
Tend to be academicians.	Tend to be practitioners or administrators.
Instruction	
Tends to be structured and didactic.	Tends to be flexible and experiential.
Tends to be focused on content.	Tends to be focused on learner and problems.
Tends to be focused on class or group.	Tends to be focused on individuals.
Teacher directs learning.	Teacher facilitates learning.

FIXED CURRICULUM APPROACH	INDIVIDUALIZED LEARNING APPROACH
Availability of Resources	
Educational institutions have libraries, laboratories, etc. which are assigned.	Learning resources are developed for choice by learners according to need.
Most "teachers" feel comfortable with traditional styles.	Requires sensitive and experienced faculty.
Depends on standard materials.	Learners' experience is a rich learning resource.
Evaluation	
Standardized tests are usually used at fixed points in curriculum.	Depends on demonstration of competence at the time.
Assessment by teacher.	Assessment by mutual evaluation of evidence.

Dr. Malcolm Knowles has used the term "andragogy" to refer to many of the concepts described here as the individualized learning approach. He contrasts andragogy with pedagogy which is the traditional form of teacher directed learning. To a considerable degree pedagogy is the fixed curriculum approach. However, there are some differences between the concepts of andragogy and the individualized learning approach on one hand, and pedagogy and the fixed curriculum approach on the other. For one thing there is no implication that either the fixed curriculum or individualized learning is necessarily related to children or adults. Nor is there necessarily any suggestion that either is for mature or immature learners.

Rather, the choices of one or the other approach, or some blend of the two, depends on the nature of the problem and the circumstances. A certain amount of the traditional fixed curriculum approach is necessary to transmit standard bits

of knowledge efficiently. It is also appropriate for many simple but standardized skills. It is by far the fastest method for dispensing a standard bit of information to a large number of people in a short time. Thus it may be the approach of choice for such situations as teaching large numbers of staff persons of an agency about a new reorganization of the agency or about the use of a new record-keeping procedure which is to be standardized throughout the organization. The instructor provides the bulk of the information, and the learners are passive recipients with little opportunity to contribute or to modify the course. They have an opportunity to ask questions to be sure that they have understood the material, but little else. It is assumed that the individuals will gear their operations to the new knowledge and procedures so there is little need to invite the learners to be flexible in the application of the knowledge to the learners' practices.

Often teaching by fixed curriculum is appropriately used for presenting background knowledge or theories, but then the method may shift to an individualized learning approach which allows the teacher and the learner to be more flexible in showing how this basic knowledge is to be applied to solve individual practice problems.

Normally a participant in a professional continuing education program is well grounded in the basic information and skills of his profession. Professional continuing education requires an element of flexibility to help the learner to explore the application of new patterns of problem solving and service delivery to his practice situation. This may require a time-extended or time-shortened effort according to each learner's need. Each learner must move at his own pace because there is no specific relationship between the learner's achievement of

competence and the length of the course.

Competent performance is the goal of both approaches. The fixed curriculum assumes that all learners in the class are starting at the same point and will reach the specific objectives at about the same time. For more complex problem-solving situations, a more individualized program of varying lengths may be more appropriate. Each learner is evaluated by tests of competence at the entry level, at specific points along the way and at exit. The more complex the behaviors involved in attaining competence from the learning situation, the more likely it is that an individualized learning approach is the method of choice. This is not to say that individualized learning is without structure. Rather, it is a system whereby a program has flexibility to change the time, format, or methods to meet individual needs.

PRACTICAL CONSIDERATIONS AND RECOMMENDATIONS FOR FIXED CURRICULUM AND INDIVIDUALIZED LEARNING APPROACHES

Both the fixed curriculum approach and the individualized learning approach are appropriate for use in continuing education in the field of mental health. There has been a long-standing acceptance of the fixed curriculum approach in much of basic professional education for the mental health professions, and this pattern tends to be carried over into continuing education. Because it is well understood and accepted by academicians, accrediting bodies and funding groups, it is often the method of instruction which is chosen, even when a more individualized learning approach would be more appropriate.

On the other hand, there are some passionate advocates of individualized learning who insist that true learning takes place only with such approaches. They would advocate this method only for every situation, regardless of cost or circumstance.

The answer lies somewhere between these two extremes. Certain parts of any worker's job require standardized knowledge and procedures which are perhaps best learned through fixed curriculum approaches. For that part of each worker's educational need which is standard, basic and concrete, the fixed curriculum approach is usually preferable. This is particularly likely to be the case with content issues, such as regulations, record-keeping procedures, reporting procedures and certain standardized administrative matters. But it is also true of much clinical expertise, such as knowing the uses, dosages, and side effects of

the major tranquilizing or anti-depressant medications or knowing the steps to be taken in a behavioral therapy program. The fixed curriculum approach is quite appropriate for learning of standardized data or the mastery of skills related to the use of standardized procedures.

Much of the work of mental health professionals relates to interactions between the worker and his clients or co-workers. The worker finds it necessary to use his or her personality to bring about changes in the client or the community. While there is a substantial base of knowledge and skills for working with emotionally disturbed people, there are also many individualized factors in the relationship between a worker and client. In this respect mental health workers differ from those persons whose work is primarily with data or things. Working in therapeutic relationships with clients involves understanding one's own values, personality, motivations, hang-ups and interpersonal style, as well as the application of basic knowledge and skills. The skills must be somewhat modified to fit each practitioner.

Self-awareness and the therapeutic use of self are best learned through flexible and highly personalized processes. Often the best learning processes are experiential -- role playing, simulations, videotape playbacks, field work with real clients and real communities and individual counseling. These experiential processes almost require an individualized learning approach.

The fact that this learning must be individualized does not mean that the learner should study in isolation. In most situations this is not desirable, rather the learner should be a participant in a small group of learners who have some of the same problems and needs. In this way the individual learner more

readily develops an awareness of his unique personality, values and style and how he can best use them in his work with clients or colleagues in ways which are different from the other participants. It does mean, however, that the learning situation must provide opportunities for each learner to experience his own personality and values, as well as to acquire the basic knowledge and skills which provide the external content for the educational program.

A common pattern is to combine the two learning approaches by providing both a fixed curriculum of didactic sessions and smaller group participation sessions where there can be experiential learning and an opportunity for the learners to explore how the new knowledge and skills can best be applied in their personal situations. This combination is particularly appropriate for those educational programs which are intended to improve individual therapeutic or administrative competencies as opposed to those which intend to convey very specific and standardized knowledge and procedures.

While this provides an overall guideline for deciding whether to use a fixed curriculum approach or an individualized learning approach for continuing education programs in mental health, there are several practical considerations which must be observed at various stages in planning and conducting any particular educational offering.

ASSESSMENT OF NEED FOR THE PROGRAM

In both fixed curriculum and individualized learning approaches the initial assessment of need for the program is done by whatever means are available and appropriate -- surveys of the potential participants, committees of selected representatives, judgments of supervisors, or data from peer review or psychiatric audit programs.

If the analysis of the need shows that the learners require only specific, concrete knowledge and standardized skills, the planners will probably choose a fixed curriculum approach. They will spell out the specific learning objectives, design the curriculum, recruit the faculty and make the arrangements for a time and place. Once all of this is done and the program is begun, there is likely to be little modification.

However, if the analysis of need shows that the learners need to know how better to apply clinical or administrative knowledge and skills which involve using themselves as the agent of change, then there is likely to be at least some planning for individualized learning approaches. The objectives are set in terms that define the competencies to be achieved and a tentative format is prepared including some specific didactic presentations and some smaller group sessions which can be programmed flexibly as more individualized learning needs become apparent. The tentative schedules, faculty, and methods are identified, and the program is undertaken. However, once the program starts, the instructors use specialized techniques to further identify just where each participant already is in his attainment of those competencies and the problems which occur in fully achieving them. These techniques may include pencil and paper tests, real case presentations, or simulated case presentations to assess how each participant would presently handle the situation and what problems the learner seems to have in doing better. It may become apparent that the learners already have sufficient knowledge and skills, but they have personal value problems (e.g., related to the chronically ill, or to alcoholics) which keep them from working effectively with certain clients.

The overall learning experiences must then be modified to meet the individualized need as determined at this point. Each learner will be given experiences which are appropriate to meet his personal problems and needs whenever possible. This approach requires considerable assessment time at the start of the program, but it is usually time well spent. Even after the program is underway, the instructors and the program director remain sensitive to newly emerging needs of the learners and make necessary program modifications. This is especially desirable in order to detect individual personality and value conflicts which are likely to remain hidden at the time of the initial assessment when the apparent needs are likely to be for knowledge and skills.

SETTING PROGRAM OBJECTIVES

Program objectives are likely to be easier to set for fixed curriculum approaches. The knowledge to be acquired is usually quite basic and specific and the skills are precise and standardized. It is relatively easy to set objectives to meet such specific targets. However, it is often much more difficult to spell out competency objectives related to effective clinical or administrative practice which involves an individual worker's style, values and personality, as well as the acquisition of specific knowledge and skills.

In both cases the objectives are set in precise and measurable terms. They both include a body of knowledge and specific skills. In the fixed curriculum approach the acquisition of knowledge and the use of specific skills are likely to be the total thrust of the objectives. In the individualized learning approach there is usually an additional element which relates to the successful application of the knowledge and skills to practice situations.

The objectives are modified for each participant in order to make them most appropriate to the practice problems of each practitioner. It is often necessary for the overall objectives of a program to be modified in some significant way after the program gets under way, but such a modification should be made only with the participation and agreement of the learners.

GAINING SANCTIONS

The issue of gaining sanction from the organization which will sponsor the continuing education program is critical, whether the program is a short-term workshop or an ongoing program over several weeks. There is likely to be little difficulty in obtaining sanction for a fixed curriculum approach because this fits the traditional beliefs of many educators that a respectable program should have a definite format and structure.

Objections to the individualized learning approach arise from the flexible objectives for each learner, from the fact that the program lacks a "firm" structure at the start, from the higher costs of individualized learning methods, and from the fact that there is no set time frame for the experience. There also may be objections from the university's point of view to using some faculty persons from agency settings and relating the knowledge to practice situations in which the procedures and controls must often be modified from the "ideal" to what is practical. A few universities have policies which require that any continuing education programs sponsored by the university must use university faculty and be held in university facilities.

However, these restrictions are fast disappearing with the increasing realization that the major purpose of continuing education is to improve the delivery

of service to clients and communities, not just to furnish knowledge.

Increasingly, continuing education programs are being cosponsored by two or more component groups (e.g., the university and the state mental health agency), so many of these objections can be overcome. Whether the program emanates from a university, a professional society, a mental health agency or a private group, there are likely to be interlocking relationships, such as joint assessment of needs, subcontracts, purchase of slots for selected employees, or stipends or other forms of tuition support. All of these are usually based on the need for individual staff persons with competence in working in service delivery programs. With this viewpoint, it becomes much easier to accept the notion of individualized learning approaches which will develop the requisite competencies as flexibly as possible, regardless of the sponsorship.

The criticism that individualized learning approaches lack firm objectives can be overcome by emphasizing behavioral terms. The objectives of individualized programs have sometimes been stated in such soft terms that it appeared that the offering was a rather lazy, "do-your-own-thing" program, but the objectives can and should be stated in much firmer terms. Similarly, the instructional programs should be provided with sufficient structure so that the learners are not simply floundering without any specific plan for learning. A few vocal exponents of the "free" university concept in which each learner sets his own educational program have given the whole concept of individualized learning approaches a bad reputation with some administrators. Individualized learning is not the same as the "free" university with its relative lack of structure.

The cost situation is a real obstacle because individualized learning approaches focus on smaller groups, and thus require more faculty. This need for more faculty can often be met by using volunteer practitioners from the field who often are pleased to do this and add a strong practical orientation at the same time. Their instruction is carried out under the overall direction of the main faculty persons. Such arrangements often make the entire program more acceptable to those who must support it.

One criticism which is sometimes made of both approaches, but particularly of individualized learning, is that the overall learning experience is too narrow and limited and that the learner does not receive sufficient cognitive information to equip him to formulate the options for professional judgments. This objection can be overcome by assuring that there is sufficient input of knowledge, theory and facts in the didactic portions of each program.

Another criticism which may be made of both approaches is that there is little evidence that continuing education makes any difference in the way people practice. There surely is need for more research and evaluation of all kinds of continuing education. However, there is increasing data to show that continuing education that is well done does, in fact, change practice behavior. Follow-up studies, medical audit programs and the like show that changes do occur. There is considerable evidence, however, that simply providing new information and even new skills is not likely to change behavior over any substantial period of time. In this regard the individualized learning approach is likely to have an advantage over the fixed curriculum approach since it confronts the affective issues (values, attitudes, personality) which are likely to be the most potent resistances to change in practice patterns.

FUNDING AND COSTING

Funding for continuing education may be on a stable basis of organizational support from regular institutional funds, or it may be based on income from fees and subcontracts for individual programs. When the funding depends on individual participants' fees, the fixed curriculum approach is likely to be advantageous since it can usually accomodate more enrollees with fewer faculty. The individualized learning approach is likely to require a higher fee. The use of some volunteer faculty will help in this regard. Individualized approaches are likely to be well subscribed -- even at somewhat higher fees, if the promotional materials make it clear that the focus is on improved effectiveness with problems in practice rather than on just the acquisition of new knowledge and skills. Agencies that are providing the fees and expenses for staff persons are especially more inclined to support programs offered with this kind of objective.

Funding may be made somewhat more stable by use of subcontracts that spell out the specific continuing education offerings to be provided over some period of time along with the competencies to be attained. The most stable form of funding is the allocation of regular institutional or agency funds. This kind of financing is especially desirable to support the overall planning, development and administration of a continuing education program, even if the support for individual offerings depends on fees from participants. This is true for either traditional curriculum or individualized learning approaches.

For any continuing education program it may be possible to obtain funding from grants, foundations, pharmaceutical firms, or book publishers. These sources of funding are usually soft money in that they are limited to a specific program or to a specified time period. They often provide for flexibility of

resources to allow for additional instructors or for more evaluation of whether the individuals have attained the expected competencies. As such these soft monies may favor individualized approaches. However, some of these funds should also be used to demonstrate the impact of the learning. Only when the cost effectiveness of continuing education and its various approaches can be readily demonstrated will it be easy to obtain hard money allocations for the entire endeavor.

The one measure on which the individualized learning approach is likely to show an advantage is in "cost per competency" when the competencies are related to skill in real life practice, but this is very difficult to measure. Much more work is needed in measurement of cost effectiveness in continuing education as well as in all aspects of mental health practice. There is a strong trend to assure that all professional education, especially continuing education, will improve the performance of the participants in the delivery of services. When an individualized learning program can demonstrate to deans and agency heads that it does in fact make a difference in the way the learners practice, it will be relatively easy to sell the higher unit cost. In the meantime it will be very helpful to document the needs of the learners and to show how the individualized learning approach is structured to improve the participants' individual performances through more targeted and personal attention.

PROMOTION

In either fixed curriculum or individualized learning approaches to continuing education there is a need to do considerable "marketing" in order to enroll sufficient participants or to obtain contract arrangements from agencies or

professional societies. The standard approach to promotion is to prepare a brochure describing the program, its objectives, the tentative agenda, the time and place, the instructors and the costs. These are either mailed out to a general mailing list or are more sharply directed to a selected group of potential enrollees. A program designed according to the fixed curriculum pattern lends itself to a wide mailing with the hope that it will be chosen by as many enrollees as possible. The individualized learning approach generally seeks a smaller and more selected group of enrollees so that mailings of announcements are more limited. In some cases the promotion may be almost entirely by word of mouth or through personal letters or negotiation with a few agency heads to plan an enrollment limited to that agency's staff members.

The announcements of individualized learning programs are more likely to stress the objective of improving the effectiveness or efficiency of practitioners in the delivery of services rather than the acquisition of new knowledge or of new skills. This should generally be the objective of all continuing education, but it is especially true of individualized learning approaches.

INSTRUCTION

The instructional programs for both fixed curriculum and individualized learning are likely to include some formal presentations of cognitive material through lectures, films, videotapes, books and reference materials. In the fixed curriculum approach these are required and standardized for all participants. In the individualized approach the specific items and sequences may be varied or omitted, or alternatives may be suggested for individual participants.

The content material tends to be the major focus of the fixed curriculum

method, while the major focus of individualized techniques is on the learner and his attainment of proficiency in specific competencies as they will have to be applied in his personal practice setting. This requires a flexible kind of instruction that in many ways is more like small group counseling or consultation than the traditional large group instruction.

The fixed curriculum approach tends to affirm the classical teacher-pupil relationship in which the teacher is the professor and learners are the students. Many professional persons, who feel they are already reasonably accomplished practitioners, resent being cast in the role of pupil in a continuing education program. The individualized learning approach, on the other hand, tends to present the instructor as a consulting expert who is working with the learners who are colleagues in a problem-solving relationship. This is likely to be far more acceptable to most practitioners who recognize that they have problems in making their work as effective as they would like and would prefer a consultative relationship to help solve their problems rather than a teacher-pupil relationship.

The fixed curriculum approach offers the same course of instruction to the whole assemblage of learners while the individualized approach makes appropriate variations in case examples, areas of emphasis and reference materials for individual participants.

In addition the individualized learning approach conducts more periodic evaluations of performance, and ends the course whenever the learners have attained proficiency as defined in the objectives, while the fixed curriculum method continues the course until the final examination on the schedule

termination date. If skillfully managed, periodic evaluations of performance can be made an integral part of the individualized instructional program. They do not need to be structured as formal "tests" or "examinations" which are likely to be resented by professional practitioners.

FACULTY

The choice of approach will often determine the faculty to be chosen for a continuing education program. Many instructors are uncomfortable with one or the other of the extreme patterns of instruction. It is probably an error to ask an instructor, no matter how competent he may be in his subject area, to assume an instructional role in which he is uncomfortable. Many expert researchers are superb in making formal presentations, but they do poorly as consultants or counselors. It is probably better to use such persons as presenters for segments of a fixed curriculum program.

On the other hand, a person who is involved in a practice situation similar to that of the learners is a colleague who can enhance their proficiency while not personally being able to claim anything like the expertise of the big name researcher. In the assessment of needs, it may be very useful to ask local practitioners who among their own colleagues might serve as appropriate faculty persons to lead small group sessions under the individualized approach. Especially when the objectives are to increase the practitioner's competence in their practice situation, the faculty should be persons chosen on the basis of practice experience as well as academic qualifications.

While special training through "faculty development" programs could improve the instructional ability of any faculty persons, it is also true that certain

persons are naturally more effective in working with mental health professionals in an individualized learning program. These persons may be found in public and private universities, in state and local agencies, in community colleges or in state and local professional associations. The director of a continuing education program may want to maintain a resource file of "capability statements" regarding local persons who have such natural abilities in the general area of mental health. The more effective programs are those that use a blend of "experts" and local persons from universities, colleges, agencies, or associations who are known to be effective in translating the expert's knowledge to the local practitioners' situation.

Evaluation studies have repeatedly shown the advisability of having handout or reference materials available for continuing education programs regardless of the learning approach. There seems to be some symbolic meaning to the learners to have such materials available. If nothing else, this gives the learners the feeling that there was some serious preparation and specific content to be learned. This may represent a reaction to programs that have, in fact, been poorly prepared without specific objectives or structure, and in which the learners felt lost.

EVALUATION

There are certain aspects of evaluation which should be carried out in connection with any continuing education program regardless of approach. These are:

> Analysis of the numbers of persons who participated, their demographic and practice characteristics, the costs of the

program, etc. These are basic evaluations of the educational process rather than its outcomes, but they are nonetheless useful.

Analysis of the participants' judgment of the excellence and relevance of the presentations and instruction, the usefulness of the materials and references, their satisfaction with the meeting time(s) and place(s), etc. These, too, are evaluations of process, but also very useful.

The analysis of what the participants have learned and whether they have reached the objectives set for the program.

In the fixed curriculum approach this is usually done with an evaluation of some kind at the end of the program. Because of the number of participants involved, it is likely to be a pen and paper test. However, it may also be a performance test if the logistics permit. At any rate the competencies of a fixed curriculum program are almost always defined in terms of attainment of specific knowledge and skills in the test situation, but this is frequently not the same as the practice situation. If the learners have not "passed" by the end of the courses, there is no remedy except to repeat the course.

In the individualized learning approach the participants are periodically evaluated against the objectives until they have attained the proficiency which

was agreed on to be sufficient for each individual at the start of the program. In many ways it holds greater promise that the learners will achieve satisfactory competence provided the objectives have been clearly defined in a way specific to their practice situations.

> At an advanced level, evaluation efforts should be made to assess whether the continuing education program has made improvements in the way the participants actually deliver services. This kind of evaluation is difficult to do and it requires some systematic follow-up in the practice situation. This may be done through special observer-interviewers; through follow-up mail or telephone surveys; through auditing of clinical records (especially if the clinical records are initially used to assess the needs for the program); through judgments of peers or supervisors; or through unobtrusive measures such as changed patterns of referral or clinical management. It is also desirable to look for "side effects" of the continuing education, that is, effects that have taken place in addition to those that were intended in the original objectives. These side effects may be either beneficial or harmful.

The major advantage to the individualized learning approach in this stage of evaluation is that the objectives have usually been set in terms of proficiency in the learner's practice situation. There is a standard against which

to evaluate the learner's perforaance several weeks or months later. In the fixed curriculum approach the objectives have usually been set in terms of a classroom competency, but there is no measure of how this will be practiced in the individual's personal practice situation.

CREDENTIALING

Credentialing must be given attention at two levels: a) accreditation of the continuing education program itself and b) awarding of certificates and "credits" to the individual participants. Since most credentialing of higher education presently follows traditional curriculum notions, the fixed curriculum approach tends to be most easily accommodated to the established mechanism.

Program accreditation, whether for the system of Continuing Education Units or of Continuing Medical Education Hours (of the American Medical Association), depends on there being an assessment of needs, specific learning objectives, a firm instructional program and systematic evaluation of learning. The fixed curriculum approach easily fits these criteria. The individualized learning approach will generally also fit, but the flexible instructional plan and the possibility of modifying the objectives may upset some traditional accreditation surveyors. On the other hand, the smaller faculty-learner ratios and the emphasis on more frequent evaluation of proficiency should be points in favor of this approach.

In regard to awarding certificates and appropriate credits to individuals, the fixed curriculum approach is likely to present no problems. Each participant must attend all of the hours of the course and is awarded a certificate showing his total of Continuing Education Units or Continuing Medical Education

hours. The individualized learning approach, in contrast, depends on the attainment of competence--not simply attending a fixed number of hours of instruction. Thus certain learners may complete the course in only one or two sessions while others require several sessions. The usual answer to this situation is to award some previously negotiated number of hours of credit for the course regardless of how long it actually requires any particular learner to achieve proficiency in the required competencies. What is really needed is a system of certifying competencies rather than hours of instruction but until this is done, continuing education directors will have to work with the existing system.

In either case the agency which sponsors a continuing education program should also have a system for keeping records of attendees, course objectives, instructors and credits awarded. Since these records are now increasingly being required by professional societies, licensure boards and employing agencies, it is important that appropriate records be kept. It would be most desirable that these records be compatible with each other regardless of the sponsorship or the learning approach. In some geographic areas the continuing education records might be centrally stored by one university or agency, but there is little experience with such a centralized record-keeping arrangement so far.

SUMMARY

There is abundant literature on both fixed curriculum and individualized learning approaches to education, largely from the field of education and related to the teaching profession. A great deal is in the literature of educational psychology. The following are some of the resources which may be useful to continuing education leaders:

Glick, Lester J. "Social Work Education: Traditional or Competency Based?" A Presentation to the Annual Program Meeting of the Council on Social Work Education, 1974.

Knowles, Malcolm. Modern Practice of Adult Education: Andragogy Versus Pedagogy. City Association Press, 1970.

Phi Delta Kappan. Special Issue of January, 1974, an education journal devoted to competency-based education.

Trivett, David A. Competency Programs in Higher Education. Washington, D.C.: American Association of Higher Education, 1975.

The interest of mental health continuing educators in individualized learning approaches has been stimulated by developments in the mental health-mental retardation field which have made it clear that traditional professional training does not always provide the worker with the knowledge, skills and attitudes which are needed for a complex system of service delivery and administration. With rapid social and technological changes, basic professional education soon becomes obsolete. Constant updating of both knowledge and skills are required to meet changing needs, but these needs manifest themselves in different ways for different individuals depending on their resporsibilities.

It is difficult for basic professional education to train people in the mental health professions for all of the many special situations they will face in the world of work. Individually oriented approaches to education have come to the fore as a method of equipping people to carry out their unique service delivery functions.

There are certain standardized parts of the knowledge and skill base which still lend themselves to traditional fixed curriculum approaches. These are most appropriate when the content of material is rather standardized, when the number of learners is large, and when the training program must be repeated several times and perhaps in several different places.

The major characteristics of the individual learning approach in education are:

The competencies to be learned are assessed individually for each learner;

The objectives are likely to have a strong affective aspect as well as knowledge and skills;

Learning is largely experiential;

Criteria and levels of performance are stated for each learner;

Flexibility of time and content are typical;

Programs are learner focused -- not teacher or content focused;

The teacher is a facilitator and counselor;

The system is based on achievement not activity or process.

These characteristics make the individualized learning approach especially suitable for much of mental health continuing education because programs can be made relevant to each practitioner's practice and his practice problems. The

fixed curriculum approach still has its place in getting standardized information quickly to large numbers of individuals.

Perhaps a mixture of fixed curriculum and individualized learning approaches will be most appropriate for most situations. This will provide a model that can reach out quickly to large numbers of persons and yet provide the depth and specificity to individuals with their unique needs. Such programs can effectively blend a faculty made up of university experts and persons from the field of practice to help translate the new knowledge and techniques into real life practice situations which make sense to the practitioners in the field. It allows for better interaction of all parties and for better feedback to the educators about the real needs and problems they must address.

Both approaches must be based on a thorough needs assessment and be related to the service delivery system. The content can be planned to meet client needs, provider needs or agency needs, but all must be related to the service delivery system as it is.

The individualized learning approach to continuing education may be more difficult to fit into the traditional educational system since it does not depend on a fixed course of instruction, a set number of instructional hours, etc. Also it tends to be somewhat more expensive than the fixed curriculum approach because of the smaller groups of learners. These guidelines have attempted to point up the problems and issues and suggest ways in which they can be solved or modified in order to meet the continuing education needs of today's mental health workers at all levels.

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